The Implementation of Measuring What Matters in Research and Practice: Series Commentary

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Series Commentary: Implementing MWM

The joint American Academy of Hospice and Palliative Medicine (AAHPM) and Hospice and Palliative Nurses Association (HPNA) "Measuring What Matters" (MWM) initiative selected and recommended ten quality indicators for hospice and palliative care practice (1) (Table 1). These quality indicators were chosen after a systematic process, relying on the existing evidence base. The intent was identification of a core set of clinically relevant, cross-cutting performance measures for use by palliative care and hospice programs to drive quality improvement efforts.

Table 1. AAHPM and HPNA Top 10 Measure What Matters Measures

National Consensus Project Domain	Measures
Structure and Process of Care	1. Comprehensive Assessment
Physical Aspects of Care	2. Screening for Physical Symptoms 3. Pain Treatment 4. Dyspnea Screening and Management
Psychological & Psychiatric Aspects of Care	5. Discussion of Emotional or Psychological Needs
Spiritual, Religious, and Existential Aspects of Care	6. Discussion of Spiritual/Religious Concerns
Ethical and Legal Aspects of Care	7. Documentation of Surrogate 8. Treatment Preferences 9. Care Consistency with Documented Care Preferences
No Applicable NCP Domain	10. Global Measure of Patient Experience

Through a special series of research and methodologic reports, members of the AAHPM Research Committee explored current application of the MWM quality indicators in research and practice (2). In this final commentary of the series, we highlight common themes and recommendations synthesized from the series, including leveraging electronic health record documentation, adapting MWM measures, implementing and tracking MWM measures, and developing new measures. We discuss each below.

Leveraging Electronic Health Record Documentation. The use of electronic health records (EHRs) to support clinical care should be leveraged to facilitate the collection and tracking of relevant data for quality measurement. Several of the papers, however, (3-6) highlight the limitations of most existing EHRs to capture data needed to track these measures. Most clinical practices, hospitals and medical centers will need to adapt current EHR templates to capture these elements, particularly information not traditionally collected by clinicians. Any additional data collection by clinicians must be balanced with the tension of not interrupting clinical practice flow.

As EHRs are adapted, new design elements should encourage and enable complete, accurate, and reproducible data capture for clinical and research purposes, which can be particularly challenging within the unstructured text of patient progress notes. For example, Aslakson et al, reported on the importance of spirituality to critical ill patients and their family members and sought to operationalize the MWM spirituality quality measure (2016). They found that while spirituality was important to an overwhelming majority of participants in the study, there were barriers to determining whether the spirituality quality indicator was met based on information in the EHR. While chaplain notes were included in the EHR, the content of the visit was not consistently described and thus it was unclear if the quality measure was met. The investigators also noted that outside spiritual support from the patient's faith community is generally not recorded in the EHR.

In contrast, Lamba et al showed that implementing a standard EHR template improved both the quality and quantity of documentation of MWM Measure 5: documentation of a discussion regarding emotional or psychological needs. However, they also found that this documentation remained mostly descriptive, and "additional prompting for documentation of recommendations to address identified emotional needs, and the use of screening tools for depression and anxiety, when appropriate, may be necessary for clinically meaningful quality improvements in patient care" (2016). In addition, several papers in the series highlighted gaps between patient preferences and the information regarding these

preferences that was available to clinicians at times of key medical decision-making (3, 4, 7). Garner and colleagues found that nearly half of veterans without a documented advance directive had named a person who could serve as a surrogate decision maker, but this information was not captured in the medical record (4). Thus, another challenge in adapting the EHR is not only to accurately capture complete patient data, but also to enable clinicians' easy and timely access to key information.

Adapting MWM Measures. Palliative and hospice care consist of practices in various locations with many patient populations. Therefore, clinicians and researchers will likely need to adapt these measures to fit their practice environment while maintaining as much consistency with MWM as possible. For example, Measure 5: Discussion of Emotional or Psychological Needs, was operationalized by LeBlanc and colleagues as a screen for anxiety or depression. However, in Lamba's study, this measure included family distress related to patient illness.

These examples of use of Measure 5 illustrate the ability to apply measures differently in various settings, but also highlight potential limitations in being able to compare results across settings if there are significant variations in operationalizing the quality measurement. Kamal and colleagues described this problem in their paper in which they examined differences in clinical documentation across settings (8). The larger goal of having a unified set of comparable, cross-cutting measures with well-defined numerators that could be used for benchmarking requires further exploration and investment.

Implementing and Tracking MWM Measures. The consensus development of the MWM list of quality indicators represented an important step forward for the field. Clinicians and practice administrators should continue to advocate for implementation and tracking of these metrics. Advancement can include exploration beyond the EHR by identifying information sources that can be utilized to inform quality of processes. Researchers can leverage these efforts to inform best practices for implementation. In addition, researchers can continue to identify areas where measures need to be

more clearly defined (3) and can validate measures in different populations and practice settings (9). Research is also needed to strengthen linkages between these process measures and patient and caregiver outcomes. Consistent application across settings will be needed to move towards benchmarking for quality improvement and to facilitate multi-site studies of quality of care.

Developing New Measures. A recent report funded by the Agency for Healthcare Research and Quality (AHRQ) reviews available palliative care Assessment Tools (10). Gaps in measures are described, including no known measures to capture cultural aspects of care. Despite identification of over 150 assessment tools, the authors report that only a handful have been evaluated in clinical practice. Dy and colleagues identified key areas of quality of care that are not captured in the current list of MWM measures, including cultural aspects of care, social aspects of care, and a specific global assessment of patient experience. Item 10 of the MWM initial set of indicators called for a measure of global quality. Gramling et al. described a new "Heard & Understood" measure to capture a fundamental feature of patient-centered care (11). The item was included by AHRQ's National Quality Measures Clearinghouse as a global measure of inpatient palliative care quality. Additional instrument development and revision of current instruments is needed to fill all of the gaps identified in the initial MWM metrics (10). In particular, a family or caregiver survey that could capture both overall caregiver experience and perceived quality of care for patients was considered of utmost importance for every patient and setting of care, but one has not yet been identified as the gold standard and benchmarked for the field.

Over our series of reports, we have highlighted the ten MWM items, focusing on issues of measurement performance, documentation characteristics, and prevalence and distribution of quality as documented by MWM items. The themes and recommendations we have presented in this commentary indicate next steps to strengthen accuracy, uptake, and reporting of the MWM items in the clinical palliative care setting. Maintaining the momentum of the Measuring What Matters initiative is critical to understanding quality through measuring what matters to patients, families and providers.

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AAHPM has created two working groups in collaboration with HPNA to build on the MWM project. The first is the Technical Specifications for electronic Clinical Quality Measures (eCQMs) workgroup, whose goal is to partner with EHR vendors and other stakeholders to develop eCQMs that matter for patients with serious illness and their families and can be used meaningfully by hospice and palliative care providers. The second is the Quality Improvement (QI) Education and Strategies workgroup, whose goals include development of QI Education tools, webinars and education modules to improve patient care and meet new requirements for value-based reimbursement that also meet CME and Maintenance of Certification (MOC) requirements. The work of these groups will highlight the need for protocols to implement MWM metrics in health systems, facilitate multi-site studies to aggregate data on MWM measures (ie, participation in the Palliative Care Research Cooperative), and develop methods to triangulate measures from several sources (EMR, quality data collected through quality improvement collaboratives such as Global Palliative Care Quality Alliance and Palliative Care Quality Network). With continued work and commitment to improving quality for patients in our field, we aspire to fulfill the original goal of the MWM project: to identify, promote, and refine measurable indicators of high quality care for seriously ill patients. To this end, we will be referring to the methodological priorities for advancing the science of quality measurement in hospice and palliative care identified by Dy, et al: 1) defining the denominator(s) (or the population of interest) for palliative care quality indicators, 2) developing methods to measure quality from different data sources, and 3) conducting research to advance the development of patient/family-reported indicators (12). Work is already underway in several projects to advance these priorities.

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